9 Station St, Mitcham 3132
487 Bridge Rd, Richmond 3121
T 03 9873 7373

BetterBacks
CHIROPRACTIC & NATURAL PRODUCTS

Massage Patient information form (please PRINT)

Name:_____ **D.O.B.**_____

Address_____Suburb_____ postcode_____

Phone numbers: home _____work _____ mobile _____

Email_____ Occupation _____Employer_____

Regular Medical Doctor or Clinic_____

Emergency Contact: (Name+**Number**) _____Relationship to you_____

Partner/ Spouse:_____ no of Children___ Do they attend this clinic? Y/N

Who is responsible for your account? Yourself/Workcover/Comcare/TAC/Veterans Affairs (please circle)

Do you hold a Concession Card? Y/N_____ Type_____

Private Health Insurance Y/N _____

What is the reason/s that you have come to this Clinic?_____

Do you have any other health concerns? _____

Sport/exercise and how often? _____

How did you find out about Better Backs? _____

Any medications (include contraceptive medications)_____

INFORMED CONSENT FOR EVALUATION AND CARE.

I understand that for the practioner to be able to make a decision on the cause of my condition, a physical examination and history will be conducted of which I agree to.

Name:_____ Signature: _____date:_____

I _____ have consulted _____ and have been advised that the following

treatment/s is best suited to my condition._____

As all health care practices carry a degree of risk; The risks associated with Massage include the following, but are not limited to, post treatment soreness, bruising. Every effort to minimize the risk of above side effects is made at this clinic, including the taking of a history and performing procedures. It is important that you reasonably answer all questions. If you have any further questions about you treatment, please ask the provider you are consulting.

I have read the above and understand or have had any terms unfamiliar to me explained and I understand the risks associated with my treatment.

I also wish this consent to cover any future adaptions to my treatment or treatment for any future conditions. I also understand that I can withdraw my consent for treatment at any time and for this to occur it requires me to tell my practioner..

Please note that all information provided to this clinic will not be passed onto any 3rd party pursuant to the Privacy Act.

DO NOT SIGN THIS UNTIL YOU HAVE CONSULTED YOUR PRACTITIONER

Patient's Signature:_____ Practitioner's Signature:_____ Date ____/____/_____